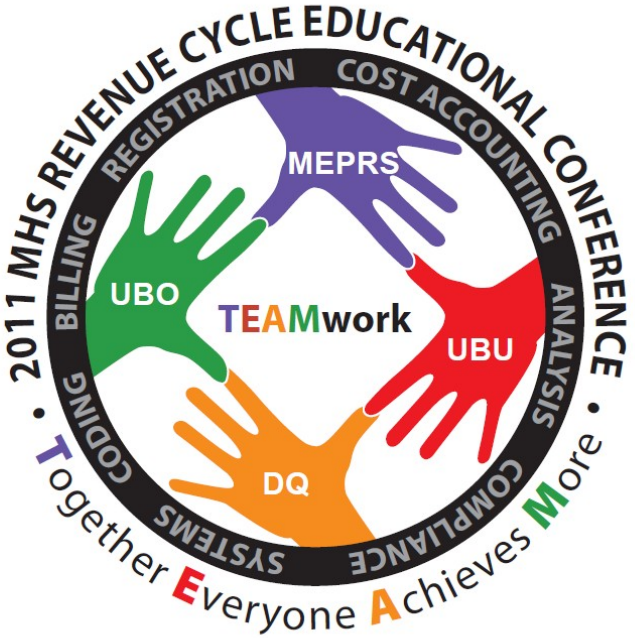


Title: **Electronic Billing — It's Your Future!**

Session: **T-2-1530**

Objectives

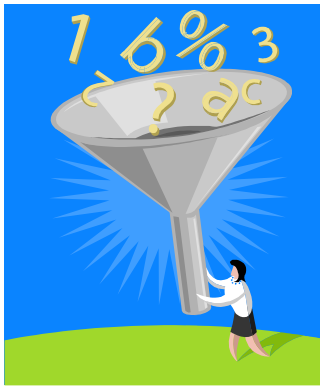
- Definition of ‘E-Billing’
- Getting Started – How It All Works
- E-Billing Benefits Your Office
- National Standards Apply
- Necessary Elements for Success
- Advantages
- Summary & Sources

Definition

- Electronic Billing
  - E-Billing Designed to
    - Transmit Claims in Electronic Format
      - 837 ASCX12 N 4010 Version – ADM, LAB, RAD Claims
        - 5010 Version Upgrade in 2012
        - Compliance Based on Clearinghouse
      - NCPDP 5.1 Version – Pharmacy Claims
    - E-Responses
      - 835 – Claim Adjudication Response
      - 270/271 – Electronic Eligibility Check
      - 276/277 – Electronic Claims Status

Definition

- Electronic Billing
  - 835 Responses
    - Within 24 Hours of Transmission
      - Payments – Paper EOB
      - EFT (Electronic Funds Transfer)
      - Denials
      - Claims Pended For Information
      - Errors
      - Data Elements Expand
        - Reporting
        - Data Analysis

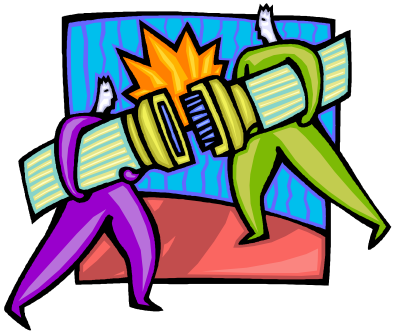


Definition

- Electronic Billing
  - Pharmacy E-Billing
    - Holding Periods & Timely Filing
      - 30 Day Filing Deadline – (Majority)
      - Commercial vs. MTF Pharmacy E-Billing
  - Statistical Analysis and Data Quality
    - Payer Utilization
    - MTF Utilization of Services
    - Payment and Denial Trends
    - Coding Errors
    - Updates and E-Communication

Getting Started

- How It All Works
  - Enrollment For Payers
    - Create Payer Listing by Utilization
    - Determine Enrollment Requirement
    - Coordinate with Clearinghouse and E-Billing Software Vendor
    - Pharmacy E-Billing May Be a Separate Process
  - 837 Claims Transmission
    - Clearinghouse Edits (Internal Edits)
      - Before Claim Goes to Carrier
      - Research/Fix Edits–Fatal Errors
        - Missing F/L Name of Patient
        - Missing NPI

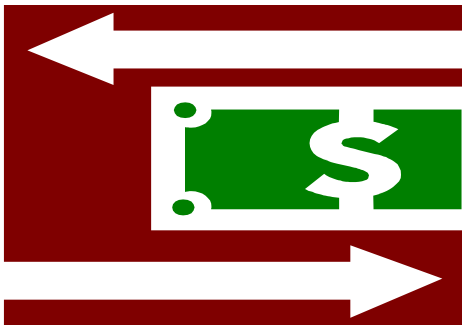


Getting Started

- How It All Works
  - 835 Payer Response Edits
    - After Claim Has Reached the Carrier
    - Name and ID Number Mismatch
    - Coverage Terminated
    - Applied to Deductible/Co-Pays
    - Retransmit Corrected Claim
    - Electronic EOBs & Paper EOBs
    - Part of Enrollment Process
    - Depends on E-Billing Vendor Feature

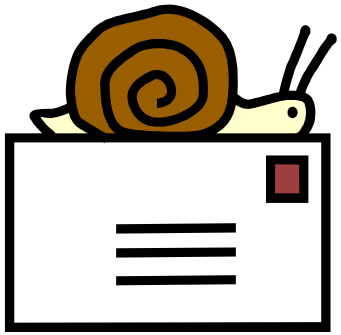
Getting Started

- How It All Works
  - EFT: Electronic Funds Transfer
    - Commercial Best Practice
    - Funds Electronically Transmitted to U.S. Treasury
    - Copy of EOB/Check Goes to MTF
      - Electronic Remittance Advice (ERA/835)
      - Paper EOB
    - Improvements to Processes
      - No More Lost Checks
      - Efficient Record Keeping
      - Staff More Productive
      - Future Is Now!



Benefits

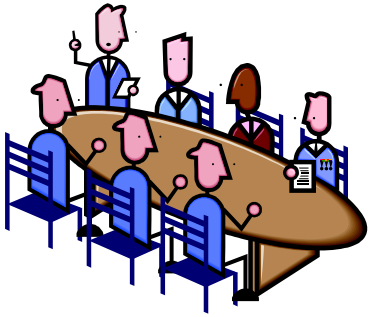
- E-Billing Benefits Your Office
  - Creates ‘Paperless’ TPC Office/System
    - Reduces Paper – Clutter – Regular Mail
      - Spreadsheets
      - Manual Calculations
  - Maximizes Staff
    - Increased Efficiency
    - Streamlined Processes
    - Increased Production



Benefits

- E-Billing Benefits Your Office
  - Electronic Files – 837 and 835
  - Efficient Record Keeping
    - Accurate OHI in CHCS
  - E-Communication with Payer
    - 270/271 – Electronic Eligibility Check
    - 276/277 – Electronic Claims Status
  - Reporting
    - MTF Specific
    - Clearinghouse

National Standards



- National Standards Apply
  - Required by HIPAA
    - Sec DHHS – Tasked to Develop
      - ASC – Accredited Standards Committee
      - NCPDP – National Council for Prescription Drug Programs
      - NUBC – National Universal Bill Committee
      - NUCC – National Uniform Claim Committee
  - National Standards Are Necessary
    - To Improve the Efficiency and Effectiveness of HealthCare
    - Uniformity
    - Formats Chosen
      - ASC X12 N Version 4010 Format
      - NCPDP Version 5.1 Format

National Standards

- Healthcare Electronic Transactions
  - Claims
  - Enrollment/Disenrollment In Healthcare Plan
  - Eligibility
  - Payment/Remittances/EOBs
  - Premium Payments
  - Claims Status
  - Referral/Certification/Authorization
  - Coordination of Benefits (COB)
- HIPAA Standards Web site
  - www.cms.gov/TransactionCodeSetsStands

National Standards

CAR	DESCRIPTION
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount

90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.

A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remi
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Ungroupable DRG.
B1	Non-covered visits.
B2	Covered visits.
B4	Late filing penalty.
B5	Coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in

Elements for Success

- Necessary Elements for Success
  - Open Communication Is IMPERATIVE
  - Payer Relations Liaison – Vital to the Process
  - Coordination – MTF – Clearinghouse – Payer
  - Track Updates
  - Brief Leadership
  - Patience Is a Virtue!

Advantages

- Brings Billing Office into the 21st Century!
- Electronic Communication with Payers
- Speedy Transactions & Responses
- Positive Impact on A/R – Keeps It Current
- EFT – Money Is in the Bank!
- Maximizes Staff

Summary & Sources

- Summary
  - Capitalize on E-Billing
  - Use Clearinghouse for Enrollments
  - National Standards and Formats
  - Payer Relations Liaison
  - Be a Resource to Your Leadership
  - Have Patience – It's Worth the Eff
  - It's Your Future! – It's Now!
  - Sources
    - www.ecfr.gpoaccess.gov
    - www.aspc.hhs.gov/adminimp/faqtx.htm
    - www.cms.gov/TransationCodeSetsStands

Questions